

should not be forgotten (in particular gonorrhoea), and tests for this should always be carried out.—I am, etc.,

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Drug Intervention in the Common Cold

SIR,—Dr. H. E. Webb's article (14 December, p. 684) and the letter from Dr. P. D. Mulkern (11 January, p. 116) certainly present ideas for debate. As more viruses are classified and discovered in association with many clinical syndromes the aetiology of disease becomes more complicated and not less. The patient's disease presents as multiple symptoms to the doctor, who attempts to make a diagnosis and tries to suppress the more unpleasant symptoms with drugs. Drug symptoms are then added to disease symptoms and the patient and doctor are worse confounded.

Perhaps we should, with Dr. Webb, look more closely at our patients' symptoms and consider them as outward manifestations of "the continually changing factors which protect the body against infection." Our treatment might more profitably be directed at stimulating those processes which naturally overcome infection, rather than at killing off the bacteria or virus which may be only one of many interacting factors in disease causation.—I am, etc.,

ANITA E. DAVIES.

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Preperitoneal Prosthetic Herniorrhaphy

SIR,—I was interested to read the letter on preperitoneal prosthetic herniorrhaphy by Mr. L. F. Tinckler (28 December, p. 832). Like him, I have become interested in the preperitoneal approach to both inguinal and femoral herniae, and my registrars and myself have carried out approximately 150 such repairs over the past eighteen months. I differ from Mr. Tinckler in my attitude towards the strength of the fascia transversalis, and at no time have I felt that this tissue could not be used for supporting sutures necessary for repair of a hernial defect. It is unnecessary, therefore, in my opinion, to use any kind of prosthesis such as Marlex mesh. Furthermore, I prefer to tackle unilateral herniae by means of a transverse incision centred more or less over the internal ring.

It is too early to use my own figures as a reliable follow-up assessment, but to date I have not found any recurrent herniation. Larger series, such as those of Nyhus and Harkins,¹ have shown that the simple preperitoneal repair of femoro-inguinal herniae is virtually recurrence-free. To complicate the operation by inserting a prosthesis is therefore hardly justified.

I have recently made a film of this operation and hope to show it at one or two surgical meetings this year and may then persuade more surgeons to adopt this simple and effective procedure.—I am, etc.,

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REFERENCE

- ¹ Nyhus, L. M., and Harkins, H. N., Editors, *Hernia*, 1964, London.

Asthma from Aspirin

SIR,—A good many years ago I read somewhere that a tiny dose of aspirin (about 1 gr. (65 mg.)) was often very effective in preventing the nocturnal wheeze of an asthmatic. Experience has shown that this is a true observation and not an old wives' tale. Could any of your readers please enlighten me as to the mechanism? I note that your leading article (4 January, p. 6) does not mention this action of the drug.—I am, etc.,

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Ichabod

SIR,—Your issue of 16 November, p. 449, has just reached me, with John McKee's "Personal View" evoking nostalgic memories of the days when general practice meant being actively engaged in the art of healing, as distinct from the duties of a medical clerk. By the same post my wife received a letter from an old friend in Britain. So aptly does it emphasize certain aspects of Dr. McKee's article that I quote this extract:

"Being ill in this country now is a nightmare. Anyone you speak to, from all parts of the country, says the same. The old idea of the family doctor and friend has quite gone. Now you are just a number. Your doctor does not bother to examine you—just gives you filthy drugs in brilliant colours. And if these do not cure you, you are sent to hospital for x-rays and tests—then operated on. You do not see your own doctor again once you have been to the hospital: he is not allowed to see you. I hate and loathe the thought of being ill."

The foregoing is no isolated experience. Over the past 18 years a continual stream of such letters have come to me from relatives and old patients in many parts of the old country. Half the world does not know (nor greatly cares) how the other half lives. Before the implosion of politics into medicine it used to be the pride of the family doctor that he thoroughly understood his patients, in all walks of life—what they did, how they thought, and how they felt. His knowledge and experience were wide, but the personal factor was one of his most potent weapons in combating and preventing disease. Without it one can only become, at best, a technician; perhaps nothing more than a janitor to the increasing ranks of "ologists." Technicians are concerned with inanimate matter and the exact sciences. Physicians handle individual people, and science is their handmaid.

When a man is sick he may indeed need the technician, but even more he requires the personal devotion of the doctor of his choice, the man in whom he believes.—I am, etc.,

Port Macquarie,
N.S.W., Australia. C. GORDON HARPER.

Experimental Cardiac Transplantation

SIR,—Dr. D. K. C. Cooper's survey of the experimental development of cardiac transplantation (19 October, p. 174) contains a significant historical error and a peculiar Figure 1. The anastomoses shown in this diagram are certainly not those by which Carrel and Guthrie^{1,2} would like to be remembered, if indeed they ever transplanted the

heart in that manner—they were too well aware of the fundamental principles involved.

The truth of the matter is that the aorta of the donor heart was anastomosed to the central end of the recipient's common carotid artery in all but one of the experiments described by Guthrie.¹ In this book he retold Carrel's² experiment, which was quoted by Dr. Cooper. I do not believe that either Carrel or Guthrie would ever have anastomosed the aorta to a peripheral vein, because they were conscious of the need to ensure the nutrition (oxygenation) of the donor heart through its coronary arteries, particularly while waiting for the donor heart to start beating. Not until the Marcus II technique³ was a method devised whereby the left ventricle produced the power for filling the coronary system. Apart from this, Carrel's anastomoses provided nearly "normal" functional conditions for the heart.

Unfortunately Dr. Cooper reinforces the erroneous impression by saying that Frank Mann⁴ brought about the crucial factor of donor coronary perfusion more simply—by direct perfusion from the recipient's common carotid artery. He refers to Mann's use of both the central and peripheral ends of this artery, but does not make clear the reasons why. Mann turned to the peripheral end because of its lower blood pressure. The higher pressure in the central end overcame the aortic valve and caused blood to collect in the heart—and distension of the heart was the main cause of failure, as Dr. Cooper noted.

In his transplantation of the heart and lungs of a kitten into the neck of a cat, Carrel used the peripheral end of the cat's common carotid artery for anastomosis to the donor aorta.^{1,2} This experiment, incidentally, continued for two days.—I am, etc.,

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REFERENCES

- ¹ Guthrie, C. C., *Blood-vessel Surgery and its Application*, 1912. Arnold.
² Carrel, A., *Bull. Johns Hopk. Hosp.*, 1907, 18, 18.
³ Marcus, E., Wong, S. N. T., and Luisada, A. A., *Arch. Surg.*, 1953, 66, 179.
⁴ Mann, F. C., Priestly, J. T., Markowitz, J., and Yater, W. M., *Arch. Surg.*, 1933, 26, 219.

Cerebral Malaria

SIR,—It was with quite a sense of shock that I read (27 July, p. 250) of the use of a synthetic antimalarial for a case of cerebral malaria. After over 30 years in East Africa I had come to rely without realizing it, but as a matter of experience, entirely on quinine in so dangerous an illness as cerebral malaria. As far as I know, parasite resistance to quinine is unknown, whereas I have had to give up all oral forms of synthetic antimalarials recently, and certainly would not dare to rely on parenteral injections of these in cerebral malaria, though these are usually effective in other forms of this disease.

I wholeheartedly agree with your correspondent, Dr. I. T. Patrick (28 September, p. 805), when he says "the most striking thing about a case of the disease is the rapidity of its deterioration once coma has set in." I would go further and omit "once coma has set in."

I was once called to a farm one Sunday morning. The patient's only complaint was a